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KHPA™

KANSAS HEALTH POLICY AUTHORITY

2009 Medicaid Transformation Program Review
Quality Improvement

Description

"Quality improvement is a formal approach to the analysis of performance and systematic efforts to improve it." The primary goal of this review of quality improvement is to measure the effectiveness of the Kansas Health Policy Authority (KHPA) in managing resources used to purchase and promote quality health care. The National Committee for Quality Assurance (NCQA) defines quality health care as "the extent to which patients get the care they need in a manner that most effectively protects or restores their health." KHPA's quality improvement efforts strive to systematically and deliberately assess, measure, and analyze data within and across programs through regular collection of core data and development of indicators focused on optimizing health outcomes and resource effectiveness.

In 2006 the Kansas Health Policy Authority (KHPA) was established to "develop and maintain a coordinated health policy agenda combining effective purchasing and administration of health care … to be exercised to improve the health of the people of Kansas by increasing the quality, efficiency and effectiveness of health services and public health programs (K.S.A. 75-7401 et seq.)." Oversight of the agency is the responsibility of an independent board of health care experts, practitioners, and cabinet officers known as the Kansas Health Policy Authority Board. Under this authority, KHPA is responsible for all of the state's publicly funded health insurance programs shown in Table 1, including Medicaid, State Children's Health Insurance Program (SCHIP), and MediKan. KHPA is also responsible for health care coverage of state employees through the State Employee Health Benefits Plan (SEHBP). The SEHBP has two components; one provides health care coverage for state employees, eligible retirees, and non-state groups. It is referred to as the State Employee Health Plan (SEHP) and is represented in Table 2. The second component manages the State Self-Insurance Fund (SSIF) that administers worker's compensation benefits for state employees. Non-state and Retirees/Direct Bill groups are not covered by this fund.

Table 1 - Public Insurance Programs and Populations Served

Type of Service	***Health Plan***	***Benefits Coverage***	***Method of Payment***	***Population Served***
Physical Health Services (Medical)	Children's Mercy Family Health Partners	HealthWave (HW) with equivalent benefits to Medicaid Fee-for-Service (FFS)	Risk Based Capitation	Title 19/21 Children Title 19 Adults
	UniCare Health Plan of Kansas	HW with equivalent benefits to Medicaid FFS	Risk Based Capitation	Title 19/21 Children Title 19 Adults
	Fee For Service (FFS) managed and non-managed care	Medicaid FFS	FFS	Title 19 Children & Adults Supplemental Security Income (SSI)/Disabled MediKan
Dental	Kansas Medicaid Program	Title 19/21 children receive identical comprehensive coverage. Title 19 adults receive emergency care.	FFS	Title 19/21 Children Title 19 Adults
Mental Health Services	Cenpatico Behavioral Health	Equivalent to the State Employee Health Plan plus two value added services	Risk Based Capitation	Title 21
	Kansas Health Solutions	Social & Rehabilitation Services (SRS)-contracted list of covered services	Non-Risk Capitation	Title 19 excluding Nursing Facility Residents (NF)
Substance Abuse Services	Cenpatico Behavioral Health	Equivalent to the State Employee Health Plan	Risk Based Capitation	Title 21
	Value Options	SRS-contracted list of covered services	Risk Based Capitation	Title 19 excluding NF and MediKan

Table 2 - State Employee Health Plan and Populations Served

Type of Service	*Health Plan*	*Benefits Coverage*	*Method of Payment*	*Population Served*
Health Plans	Plan A: BlueCross/BlueShield Coventry/Preferred Health Systems/UMR a United Healthcare Company.	Physical Health/Mental Health/Substance Abuse Treatment	Shared between State and member*	Active Employees Non-State Employer Group/Retiree/Direct Bill Group
	Plan B: BlueCross/BlueShield Coventry/Preferred Health Systems/UMR a United Healthcare Company.	Physical Health/Mental Health/Substance Abuse Treatment	Shared between State and member*	Active Employees Non-State Employer Group Retiree/Direct Bill Group
	Plan C: Coventry/Preferred Health Systems/ UMR a United Healthcare Company.	Physical Health/Mental Health/Substance Abuse Treatment	Shared between State and member*	Active Employees Non-State Employer Group
	Medicare Plans: Coventry Advantra Freedom PPO/Coventry Advantra Freedom PFFS/Humana Group Medicare PPO/Humana Group Medicare FFS/Kansas Senior Plan C	Physical Health/Mental Health/Substance Abuse Treatment	Member	Retiree/Direct Bill Group
Dental	Delta Dental	Comprehensive coverage	Shared between State and member*	Active Employees Non-State Employer Group Retiree/Direct Bill Group
Pharmacy Benefit	Caremark	Prescription Drug coverage with Preferred Drug List and tiered payment.	Shared between State and member*	Active Employees Non-State Employer Group Retiree/Direct Bill Group
	Coventry Part D/ SilverScript/Humana Part D	Prescription Drug coverage with Preferred Drug List	Member unless they qualify for low income assistance then shared between member and Centers for Medicare & Medicaid Services (CMS)	Retiree/Direct Bill Group
Vision	Superior Vision	Option for a basic coverage or enhanced coverage	Shared between State and member*	Active Employees Non-State Employer Group Retiree/Direct Bill Group
Health Savings Account	UMB Bank/Health Equity/American Chartered	Qualified medical related expenses	Shared between State and member*	Active Employees/Non-State Employer Group
Flexible Spending Account	Application Software, Inc (ASI) Flex	Qualified medical related expenses	Member	Active Employees

* The State contributions for healthcare apply to active employees only

KHPA purchases medical care for nearly one half-million Kansans each year, with total expenditures nearing two billion dollars annually. KHPA disburses these dollars as health care payments to thousands of providers while limiting agency administrative costs to 4.78% of all-funds or 5.06% of State General Funds during the State Fiscal Year (SFY) 2009 budget. To provide direction in policymaking and program administration the KHPA Board established six vision principles. Those vision principles include three that are focused on quality in health care:

- *Access to Care*. Every Kansan should have access to patient-centered health care and public health services ensuring the right care, at the right place, and the right price. Health promotion and disease prevention should be integrated directly into these services.
- *Quality and Efficiency in Health Care.* The delivery of care in Kansas should emphasize positive outcomes, safety and efficiency and be based on best practices and evidence-based medicine.
- *Stewardship*. The Kansas Health Policy Authority will administer the resources entrusted to us by the citizens and the State of Kansas with the highest level of integrity, responsibility, and transparency.

Stewardship over such a large portion of the state's resources requires public oversight, trust, and involvement. Transparency is an integral component of KHPA's vision principles, and the agency is engaged in a broad range of activities to make program and other health information widely available to stakeholders and the general public. KHPA values public reporting for what it serves to contribute by:

- Exhibiting accuracy and accountability in KHPA programs including those administered by contracted providers such as the Medicaid Managed Care Organizations (MCOs).
- Supporting the greatest choice of plans and programs possible for beneficiaries.
- Informing stakeholders and policymakers about program strengths and needs.
- Supporting better policy making.
- Encouraging continuous quality improvement.

National and State fiscal deficits have resulted in reconsideration of all existing appropriations of funds and additional funding requests. Although KHPA is mindful of these financial issues, the goal of improving quality outcomes and effectiveness remain unchanged. It is important to note that information about the quality of services provided by various health care programs operated by KHPA should be useful not only in good times, when program expansion is an option, but in tough times as well, when policy makers must make difficult decisions about their most effective-and least-effective appropriations of public dollars.

The State Employee Health Benefit Plan (SEHBP) which includes the State Self-Insurance Fund (SSIF) has also been impacted by these overall budget reductions. The costs of these plans are shared among the 102 state agencies.

Current Quality-Related Strategies and Initiatives

In 2008, KHPA implemented the following strategies to identify and address opportunities for promoting the improvement of the quality of care purchased through our health care programs:

- Assessing and monitoring regularly and systematically the available quality data:
  - Standardized data routinely collected from surveys and administrative health data

    - Targeted analyses and special data collections
- Identifying measures across KHPA programs to compare quality and enhance coordination of health care purchasing
- Working with program managers and agency leadership to review program quality data and make that data available to the public
- Recommending quality enhancing policies to program managers and agency leadership

Based on the 2008 Quality Program Review findings, recommendations were made to focus the agency on quality improvement and quality health care.

- Establish baseline levels of program performance and publicly share these results; sharing quality data facilitates understanding, motivates change, and informs stakeholders
- Publish quality and outcomes data currently collected for the HealthWave and HealthConnect programs. Publication of those data will complement the work of the KHPA Data Consortium, an advisory group to the KHPA Board, which is tasked with developing recommended quality indicators and health measures for the state
- Obtain funding for new data collection initiatives. In order to evaluate performance, identify opportunities for improvement, and facilitate comparability across programs, data should also be collected from beneficiaries and providers participating in the fee-for-service program
- Promote the use of health information technology (HIT) in the Kansas Medicaid and the State Employee Health Plan programs by implementing a Community Health Record for all program participants statewide. Two HIT pilots have been fielded: the Community Health Record Pilot and the CareEntrust Pilot. KHPA supports the use of HIT based on evidence that will facilitate better coordination of care, improve health outcomes, and ultimately reduce health care costs

During March and April 2009, internal interviews were conducted with KHPA Program Managers to determine the extent to which the strategies and recommendations (identified in 2008) had been implemented. Program areas and specific findings collected during the interview process are referenced in Tables 3 and 4. General findings included:

- Implementation of quality strategies and recommendations is on-going
- Publication of existing Medicaid reports continues and is expanding
- Program managers find establishing baseline program performances through the program review process useful
- Regular use of data to review and direct day-to-day program management has not occurred
- Global strategies, as part of an overall quality plan, are less effective if program level strategies are not implemented to motivate change through the use of data
- Within Medicaid, the perception of data limitations and data processing systems overload are cited as primary obstacles to the data review process
- Many of those interviewed expect the implementation of the Data Analytic Interface (DAI) project (described later) to alleviate these obstacles and provide benchmark references

The SEHBP recently made changes to their data system and receives encounter or claims data from the contracted plans to populate the data system that can be queried by KHPA staff. Note: To date, written program reviews have been limited to Medicaid programs. Therefore, self-evaluation of programs purchased through the SEHBP has not occurred outside of contract performance oversight. SEHBP managers were included in the interview process, however,

and the information collected has been summarized later in this report. The SEHBP programs will be incorporated into the agency-wide program improvements beginning in 2010.

In addition to specific programmatic reports and data utilization, KHPA has initiated statewide quality efforts that support and enhance the quality improvement process and include measures designed to improve the delivery and quality of health care. These initiatives are:

Data Consortium

This advisory group of community experts and stakeholders began meeting in December 2007. KHPA asked the Consortium to develop a set of measures for health indicators related to four of the six Vision Principles mentioned previously:

- Access to Care
- Affordable, Sustainable Health Care
- Quality and Efficiency
- Health and Wellness

Four working groups completed this objective. The report and recommendations were presented to the KHPA Board in March 2009.
http://www.khpa.ks.gov/KHPADataConsortium/Docs/DataConsortiumHealthIndicators.pdf
KHPA maintains and updates these indicators, and has engaged the consortium with the ongoing responsibility of expanding use of available data, and identifying a limited number of new data to complete a comprehensive assessment of health in the state.

State Quality Institute

In 2008, Kansas was selected as one of eight states to participate in the State Quality Improvement Institute (SQI), funded by the Commonwealth Fund and administered by Academy Health. In June 2008, several KHPA staff attended the Commonwealth Fund's State Quality Improvement Institute, where strategies for developing and implementing the medical home in Kansas were discussed. KHPA is using an adapted Commonwealth Fund definition of the medical home with the emphasis on transforming the health care system from one that reacts to illness to one that provides proactive, comprehensive, and coordinated care to keep people with chronic illnesses as healthy as possible and help healthy people maintain their health through prevention and promotion activities.

Medicaid Transformation

The KHPA Board convened a subcommittee to oversee Medicaid Transformation and report its recommendations for improvement to the full board. The purpose of the transformation process is to assess major program and service areas with the objective of improving efficiency and quality and to identify trends in expenditures. As part of the transformation process, program managers reviewed 14 programs and service areas, generating program-focused reports with recommendations for change during the upcoming year. The program reviews were published in January 2009 and can be found at http://www.khpa.ks.gov/program_improvements/default.htm. Status toward implementing these recommendations are reviewed later in this document and presented in an at-a-glance table (Table 3). An additional 13 program and service areas are being reviewed during 2009.

Medicaid Transformation Grant

Passed by Congress in 2006, the Deficit Reduction Act (DRA) authorized new grant funds to states for the adoption of innovative methods of improving effectiveness and efficiency in Medicaid. The Kansas Health Policy Authority received a grant from the Centers for Medicare & Medicaid Services (CMS) to use electronic claims data to promote health in persons with disabilities. The Health Promotion for Kansans with Disabilities Project was a one-year intervention involving four Community Developmental Disability Organizations (CDDOs) and three Independent Living Centers (ILCs) from primarily rural locations across Kansas. During the intervention, case managers and independent living counselors accessed an electronic, on-line tool called ImpactPro (Ingenix Corporation) that contained a 12-month Medicaid claims history for their consumers. Case managers reviewed inpatient (e.g., hospital) and outpatient (doctors, physical therapists, laboratory test, etc.) visits as well as prescription medication claims to determine what types of services their consumers had accessed. In addition, ImpactPro screened the claims to determine if there were any opportunities to improve the quality of care for the consumers. For instance, if a consumer was identified as diabetic and has not had his or her hemoglobin A1C (a blood test) measured in the last twelve months; ImpactPro flagged the record indicating this gap in care. The final report for this project will be available by the end of the summer of 2010.

Medical Care Advisory Committee (MCAC)

The MCAC is an advisory group required in federal regulation (42 §CFR 431.12) to advise the Medicaid agency about health and medical care services. The committee membership represents health care professionals including physicians, members of consumer groups including Medicaid recipients, and the director of the public health department. The committee reviews medical literature and aggregated population data to advise KHPA regarding medical services and items for potential coverage or continued coverage through KHPA Medical Plans. The MCAC is tasked with developing recommendations regarding data collection for program evaluation and the development of quality initiatives. Meeting schedules, agendas, supporting documents and final minutes are posted on the KHPA website at; http://www.khpa.ks.gov/advisory_council/mcac/default.htm. This committee met three times in 2008. Much time was spent educating the members on Medicaid and the policy process. One coverage decision was reviewed and recommendations were made to KHPA.

KHPA Internal Quality Workgroup

Implementation of the KHPA Internal Quality Workgroup began in 2008 and continues to develop in 2009. This workgroup has been established with a cross-sectional membership representing each of the health care products across the agency. This group met twice in 2008 to establish the group purpose to review quality reports for public posting and recommend cross-program comparison measures. A Provider Survey was reviewed, amended, and recommended for posting to the KHPA Leadership team.

Publishing Quality Reports

KHPA has developed and implemented public web pages on its website for posting of quality reports. This site was launched January 14, 2009 and is located at; http://www.khpa.ks.gov/quality_reports/default.htm. This website provides:

- Healthcare Effectiveness Data and Information Set (HEDIS) with comparison between the managed care and PCCM plans.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey results with comparison between the managed care and primary care case management (PCCM) plans
- Provider Survey results and cross-program comparison tables
- External Quality Review Organization (EQRO) annual report

Health Information Technology

KHPA implemented three initiatives to promote use of health information technology. These initiatives are:

- *Community Health Record Pilot*

  The Medicaid Community Health Record Pilot was designed to be used by providers treating beneficiaries in Sedgwick County. The project was launched with the expectation of having 40 provider sites enrolled and actively using the system. Providers were given secure internet access to beneficiary health records populated by claims information. Providers' access was to allow review of these records for information such as past hospitalization, physician visits, medications, diagnoses, procedures, allergies, immunizations and Early Periodic Screening, Diagnosis and Treatment (EPSDT) forms completion, and to allow limited ability to update the patient record. It was hypothesized that the providers' use of information gained through the Community Health Record would lead to better coordinated healthcare, improved health outcomes, and potentially reduced health care costs by reducing duplicated services. Integration with the immunization registry, activation of Kansas EPSDT forms, and full e-prescribing components did not occur in a timely fashion; provider use of the product did not meet expectations therefore realization of the anticipated benefit was not achieved. This project will not be continued based on the state's fiscal situation and non-achievement of the desired outcomes.
- *CareEntrust Pilot*

  The CareEntrust product is a State Employer Based Community Health Record. This pilot is located in the Kansas City metropolitan area and is limited to a sample of State Employee Health Plan members. This project utilizes the same health information technology platform as the Medicaid Community Health Record pilot, providing secure internet access to the consumer's personal health record which is shared with healthcare providers based on consumer preferences. Performance based reporting has not been available from the vendor therefore scientific measures of outcomes have not been clearly established. This contract was terminated due to budget reductions.
- *Data Analytic Interface (DAI)*

  The DAI is a tool designed to provide desktop data access. The DAI allows KHPA staff to obtain health care program data from sources such as Medicaid, SEHBP, and the Kansas Health Insurance Information System (KHIIS). Enhanced access to data is expected to increase program evaluation by improving learning within the organization, providing comprehensive surveillance of medical utilization trends and expenditures, and by measuring health outcomes. The data will also be used to improve transparency and understanding and to assist in the development of health policy. This project is now in the implementation phase, with access to approved users beginning in January 2010. All KHPA program staff will use this tool to enhance productivity in day-to-day management.

Quality Expenditures

Medicaid

Data is not readily available regarding the cost of collecting and reporting information relevant to quality improvement. With few exceptions, costs are neither separately defined nor identified within contracts or program oversight. The exceptions are federal requirements creating specific deliverables from the managed care contractors. KHPA has mirrored those requirements in the PCCM program. Those services are delivered through the External Quality Review Organization (EQRO) and represent expenditures based on calendar years (CY). The projected contract amount is approximately $1 million per year from CY 2009 through CY 2014. These costs are split with the federal government.

In addition, KHPA has a Utilization Review contract for inpatient claims. The contract amount from SFY 2009 through SFY 2012 represents a total of $5.1 Million. This contractor performs utilization review of a representative sample of inpatient claims paid through Medicaid. The UR contractor analyzes the medical care provided to Kansas Medicaid clients through application of Care Web QI and calculates AHRQ quality indicators. Care Web QI is a web-based software extension of the Milliman Care Guidelines, the utilization screening tool used for admission and other reviews. This software uses the concept that variation from the expected course of recovery can signal opportunities for improvement in care.

AHRQ indicators are based on claims analyses and are intended to provide information that can draw attention to high- or low-performing hospitals in several clinical areas. There are three general categories that are reported: Patient Safety Indicators, Pediatric Quality Indicators and Inpatient Quality Indicators. Any quality of care concerns identified through this process are referred to a physician peer reviewer and, if confirmed, reported to KHPA for follow-up.

State Employee Health Plan

Plans contracted through SEHP primarily produce financial compliance reports with no requirement to assess or report health outcomes. The plans provide claims data that are placed into the data system managed by SEHP staff who have the ability to query the database. The data system is purchased through a vendor at an annual cost of $301,800. The data system has now been fully integrated with Medicaid information in the DAI, enabling comparison of financial and health putcomes.

Public Reporting on the Quality of Medicaid Health Plans

State Reporting

Federal regulations require that states incorporate performance measures into their quality assurance strategies for managed care. Although public reporting of these measures is voluntary, some states make this data available on-line. However, comprehensive reviews to evaluate the states' most current efforts are limited. One of the most recent studies conducted, *Public Reporting of Quality Information on Medicaid Health Plans,* was published in the spring of 2007. This report provided an overview of the extent to which Medicaid health plan quality information was available online during selected periods of time. Medicaid managed care programs reviewed included the following:

- For-profit versus not-for profit

- Larger versus smaller plans
- Medicaid dominated (more than 75 percent of total enrollees were Medicaid beneficiaries) versus other Medicaid serving plans (less than 75 percent of total enrollees were Medicaid beneficiaries)
- Provider-owned versus other ownership types (within the Medicaid dominated category)

Plan-level data on quality measures were obtained from reports available on the state Medicaid websites or other websites (e.g., state health departments) during the fall of 2004 and again in the fall of 2006. Highlights of the authors' study and findings are described below.

States that Reported:

- Most of the states with large full-risk Medicaid Managed Care (MMC) programs publicly reported some quality-related data by plan (i.e., 17 of the 20 with more than 200,000 enrollees)
- States with smaller programs tended not to report (11 of 15)
- States that publicly reported quality data tended to have more of their plans accredited by the National Committee for Quality Assurance (NCQA)
- Several of the states that did not publicly report had only one health plan in their program at the time of the review (i.e., Kentucky, **Kansas**, and North Dakota)

Types of Measures Reported

- The most frequently reported HEDIS like measures focused on women and children's health and chronic care measures and included:
    - Prenatal care
    - Appropriate medications for asthma
    - Well-baby visits
    - Well-child visits
    - Well-adolescent visits
    - One or more measures of comprehensive diabetes care
- Types of HEDIS measures less frequently reported related to:
    - A smaller proportion of most states' Medicaid populations (e.g., measures of blood pressure, beta blocker after heart attack, cholesterol management after cardiovascular events)
    - Mental illness or substance abuse treatment
    - Dental care
    - Methods relying on self-reporting (e.g., smoking cessation)
- Global CAHPS ratings of member satisfaction were reported by 19 states, although the states varied in which ratings were reported (i.e., doctor or nurse, specialist, health plan, and /or health care)
- In addition to reporting the global measures, 17 of the 19 states reported data on at least one of the five CAHPS composite measures and/or their individual question components which included:
    - Getting care quickly
    - How well doctors communicate
    - Courteous and helpful office staff
    - Helpful office staff

Based on their findings, the authors concluded that while progress in public reporting has been made, shortcomings remain.

Progress

- Access to publicly available clinical quality or access to data online was provided in 21 states, including 17 of the 20 largest programs
- Access-related and clinical HEDIS and CAHPS measures were reported to accommodate both the consumer's perspective and the clinical measures
- The availability of HEDIS and CAHPS instruments have led to relatively standardized methods of data collection and reporting

Shortcomings

- Data were difficult to find for about one-third of the states:
    - The data were located on the state department websites
    - Reports were either broken or erased from the Medicaid website
    - Data were embedded in the publications and reports section of the Medicaid website, etc.
- The ability to combine relevant data for analysis on a national level is to some extent impeded by minor state-specific age group variation from the standard HEDIS definitions and by different ways of reporting on the CAHPS data.
- Publicly reporting quality data is voluntary and requires effort to access.

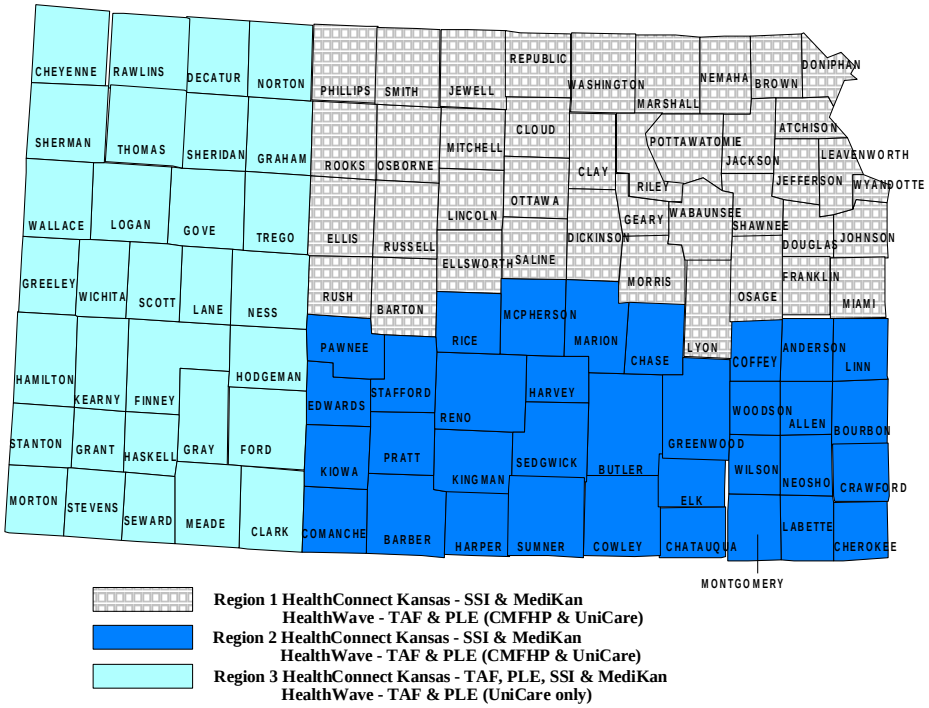
The authors noted that the *U.S. News and World Report "Best Health Plans"* provides a list of high-performing states and health plans, including the top five Medicaid health plans based on NCQA analysis of HEDIS data used in accreditation scoring. This report may be accessed by visiting this link: http://health.usnews.com/articles/health/health-plans/2008/11/07/americas-best-health-plans-honor-roll.html and scrolling down to "Best Medicaid Plans."

> Source: *Public Reporting of Quality Information on Medicaid Health Plans,* Felt-Lisk, S; Barrett, A.; and Nyman, R; Health Care Financing Review, Spring 2007, 28(3).

Transparency is an integral component of KHPA's vision principles, and the agency is engaged in a broad range of activities to make information widely available to stakeholders and the general public. At the time of the aforementioned study, Kansas was one of the (smaller) states that had no public reporting and only one managed care health plan. Progress has been achieved through:

- The public posting of CAHPS, HEDIS and program specific reviews
- The redesign of the KHPA website to create a tool which is more intuitive for the user
- Managed care options for beneficiaries have been expanded to two plans in the Regions 1 and 2 as shown in Figure 1.

Figure 1



Program Review

During March and April 2009, Program Managers participated in brief interviews to discuss quality improvement efforts related to the programs and services for which they are responsible. The interview findings have been summarized in Tables 3 and 4, providing a status of implementation activity of the 2008 recommendations.

The fiscal crisis occurring in Kansas and across the nation has affected all activities requiring consumption of resources; as a result activities demanding additional funds have not moved forward.

Generally, data evaluation for day-to-day program monitoring has not been implemented. The perception of data limitations and the difficulty of using older data processing systems are cited as primary obstacles to this process. Most program managers report that once DAI is launched, issues pertaining to access and use of Kansas Medicaid data and available national benchmarks are expected to improve significantly.

Table three reports progress of the KHPA staff in implementing recommendations as of March and April 2008. Significant progress has been made since that time. This table represents a transparent process for self-reporting in support of continuous program improvement. The table will be updated annually.

Table 3 - 2008 Program Recommendations: Program Interviews Medicaid

Program	*2008 Recommendation*	*Brief Status as reported by Program Managers*
HealthConnect Kansas	• Review this program's model as a primary care gatekeeper and work with stakeholders to develop plans to implement a medical home in order to reduce the rising costs of chronic disease.	• Development of a care management, medical home model is underway focusing on the aged and disabled population.
HealthWave	• Make comparative health plan performance and health status quality data available for consumers, policymakers, and other stakeholders in 2009. • Highlight wellness and prevention efforts for families.	• Publicly posting of performance reports has been implemented and continues to be expanded. • Due to fiscal impact and contract reductions additional requirements have not been added to the plans.
Medical Services for the Aged and Disabled	• Convene stakeholders to help evaluate and design a statewide care management program for the aged and disabled aimed at slowing the growth of health care costs through improved health status.	• The program report has been provided to the Medical Care Advisory Committee. • The final report will be available in the summer of 2010, at which time quality performance measures will be established.
Emergency Health Care for Undocumented Persons	• Monitor changes in border state policies regarding immigrants and assess the impact on Kansas.	• Routine monitoring reports have not been created.
Dental	• Extend prevention and restorative coverage to adults enrolled in Medicaid.	• Expansion is unlikely given the budget issues.
Durable Medical Equipment (DME)	• Require DME suppliers to show actual costs of all manually priced DME items, ensuring reimbursement is no greater than 135% of cost. • Review potential overpayments and coverage usage issues, specifically for oxygen services.	• DME providers are being required to provide proof of actual costs and pricing is being set as recommended. • Review of potential overpayments occurs through the State Utilization Review System (SURS).

Program	*2008 Recommendation*	*Brief Status as reported by Program Managers*
DME (continued)		• Revision of entire oxygen service and benefits is in progress. • Scheduled or regular data reports have not been created.
Home Health	• Limit home health aide visits. • Develop separate acute and long-term home health care benefits with differential rates that reflect the intensity of services over time.	• Policy has been created limiting home health aide visits to a maximum of 2 per week. • Differentiation of rates by level of service requires policy implementation and Medicaid Medical Information System (MMIS) changes have not occurred. • Scheduled or regular data reports have not been created.
Hospital	• Adopt severity adjustment payment system for inpatient services (MS-DRG), review outpatient reimbursement, and emergency room use. • Follow Medicare rules on refusing to pay for "never-events" in order to improve patient safety.	• Differentiation of rates by level of service requires policy implementation and MMIS changes have not occurred. • Policy E2009-039 has been written to implement system changes for "Never Events" as adopted by Medicare. • Scheduled or regular data reports have not been created.
Hospice	• Enhance scrutiny of retroactive authorizations for hospice services. • Review concurrent Home and Community Based Service (HCBS) stays. • Increase scrutiny of pharmaceutical coverage and spending. • Review extended patient stays.	• Program manager has no direct relationship with SURS however may identify providers to be reviewed. • Concurrent review of service through HCBS and review of beneficiaries with extended service through Hospice is ongoing. The Centers for Medicare and Medicaid have defined these two programs as non-duplicative and may coexist on a case/case basis. • Increased monitoring of

Program	*2008 Recommendation*	*Brief Status as reported by Program Managers*
Hospice (continued)		pharmacy claims to ensure only appropriate drugs are being provided as consistent with Hospice philosophy has occurred. • Scheduled or regular data reports have not been created.
Lab/Radiology	• Review coverage of new procedures and explore adoption of the Medicare payment system as a starting point for reimbursement of all new procedures, and ensure appropriate payment over time.	• New procedure codes are priced based on Medicare. Codes already in existence within the system remain unchanged. • Scheduled or regular data reports have not been created.
Pharmacy	• Revise Kansas law to allow for the use of direct management techniques, such as safety edits and the Medicaid Preferred Drug List (PDL) and Prior Authorization (PA) lists, for selected mental health medications. • To inform these decisions, use a newly established, specialized mental health advisory committee. • Purchase an automated PA system to ease and expand use of PA, and to ensure timely dispensing of medications.	• KHPA was not successful in obtaining changes to Kansas' law allowing safety edits for mental health medications. • Mental Health Advisory Committee has been formed and met for the first time in June 2009. • Limited automated prior authorization was implemented April 1, 2009.
Transportation	• Issue a request for proposal to outsource management and direct contracting for Medicaid transportation benefits to a private broker in order to increase scrutiny, right-size reimbursement, and generate modest net savings for the state.	• RFP 12073 was issued and closed May 5, 2009. • The contract was signed August 6, 2009 with an implementation date of November 1, 2009.
Eligibility	• Promote community-based outreach by placing state eligibility workers on-site at high -volume community health clinics around the state. • Expand access to care for needy	• Promoting community-based outreach has been included in a grant request. All additional requests for funding are on-hold due to state budget issues.

Program	*2008 Recommendation*	*Brief Status as reported by Program Managers*
Eligibility (continued)	parents by increasing the income limit to 100 percent Federal Poverty Level (FPL) ($1,467 per month for a family of three). • Increase eligibility limits for the medically needy (primarily elderly and disabled people who do not yet qualify for Medicare) so that it is tied to the federal poverty level. • Increase the number of people who have access to full Medicare coverage through Medicare savings plans.	• Expansion of the adult population served by Medicaid must become a legislative issue to be funded. All additional requests for funding are on-hold due to state budget issues including increasing eligibility limits for medically needy or assisting with Medicare Savings Plans.
Quality Improvement	• Publish quality and performance information that is already collected for the HealthWave and HealthConnect programs to increase transparency. • Obtain funding for the new collection of data from beneficiaries and providers in fee-for-service programs to evaluate performance, identify opportunities for improvements, and facilitate comparability across programs.	• Publication of managed care quality reports began January 14, 2009. Other programs are to be incrementally added to this site. • Requests for additional funds are on hold due to state budget issues.

State Employee Health Benefit Plan

Table 4 - 2008 Program Recommendations: Program Interviews State Employee Health Recommendations

Program	***2008 Recommendation***	***Brief Status as reported by Program Managers***
State Self Insurance Fund (SSIF) (Worker's Compensation Fund)	• Data management software was installed March 13, 2009; the staff are in the process of learning how to create reports. • Dashboard add-on is requested in 2010 budget, but will likely be pushed to 2011.	Program update not available.
SEHBP (Health Plan Operations)	General Discussion: • No new quality initiatives for 2010, due to budget cuts; • The reports done by this unit are primarily claims/cost oriented - not quality related; • Claims data goes into the Thomson Reuters system specific; SEHBP staff run the reports and analyzes the data.	• They have looked at HEDIS measures, but not all of their plans use HEDIS, so comparisons aren't possible across the board. • Data not related to claims (e.g. phone response times) are self-reported by the plans and cannot be validated. • Vendors are not contractually required to report grievance information to KHPA. Calls that come through KHPA are logged.

SEHP - Membership Services (State Employees, Retirees, Non-state agencies and Consolidated Omnibus Budget Reconciliation Act COBRA)	• Quality Measures:
	  ○ Are eligible people enrolled?
	  ○ Are ineligibles not enrolled?
	  ○ Are premiums being paid correctly?
	• Customer satisfaction data is collected with open enrollment process and materials and through Survey Monkey.
	• Data integrity - about 50 queries are run twice/week to check for such issues as valid SSN, dependent over age 23, premiums not paid for 2 or more months (possibly indicating a death), etc. These are flags for ineligibility.
	• Accurate/timely billing - queries have uncovered problems in this area.
		• Goal is to move toward a paperless, automated enrollment process (about 25,000 were hand entered last year).
		• Death records are not currently accessed by KHPA from Kansas Department of Health and Environment (KDHE).
		• Process changes for billing are in the implementation phase.

Quality Improvement Recommendations

Continued improvement relies on KHPA's ability to measure progress and identify additional opportunities to refine this process. The following recommendations provide global direction to continue the evolution of the quality improvement process and promote program specific recommendations to bring the philosophy of quality into the daily activity of each person within the Agency.

1. Develop and implement strategies to ensure the use of data at the program level.
2. Incorporate quality data analysis as a key element of each program/service review.
3. Require new and renewing contracts to include the collection of core data, development of quality measurement and reporting back to KHPA in a format standardized across all products.
4. Expand program reviews to include all products purchased through KHPA.
5. Revise strategies to ensure further attainment of incremental quality improvement targets.